SAMPLE DENIAL LETTER

FOR THE COMMONWEALTH COORDINATED CARE PLUS (CCC PLUS) WAIVER OR PROGRAM OF ALL INCLUSIVE CARE FOR THE ELDERLY (PACE) OR NURSING FACILITY SERVICES

DATE

Mrs. Mary Jones
0000 Avenue
Home Town, Virginia 00000

Dear Mrs. Jones:

Purpose of this letter:

This letter is being sent to you in response to your recent screening for Medicaid-funded long term services and supports (LTSS). These services may include home and community based services or nursing facility care. Home and community based services include the options of: the Commonwealth Coordinated Care Plus (CCC Plus) Waiver or the Program of All Inclusive Care for the Elderly (PACE) program. The Virginia Department of Medical Assistance Services (DMAS) requires that an individual seeking LTSS be screened to determine if they meet the level of care criteria for services provided in a LTSS setting. Individuals must also be screened to determine financial eligibility for Medicaid, or if the individual expects to become financially eligible within 180 days of the start of services.
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What this screening means for you:

The screening team, in accordance with Medicaid regulations, policy and procedures, with your input, have determined that you do not meet the level of care criteria for Medicaid-funded LTSS because **[Screener - Insert the specific reason(s) why the individual does not meet the criteria and add: 12 VAC 30-60-303].**

This determination is based on the screening team's assessment of your functional abilities, medical and nursing needs, and overall risk of requiring institutional care.

[Screener - When a referral is made to any community agencies/resources, insert this information here]

[Screener - When a referral is made to the Community Services Board or other community agencies/resources for active treatment, insert the paragraph below as follows:]

Your service needs:

It has been determined that you are in need of active treatment for a condition of Mental Illness, a Developmental Disability or related condition. This determination is based on the assessment of your functioning abilities, medical needs, psychological needs, and need for active treatment. A member of the local Community Services Board (CSB) or other community agencies/resources will be in contact with you to arrange for active treatment services.

You have the right to appeal this decision:

If you do not agree with the decision provided in this letter, you may ask someone else to review your

request for services. This is called an appeal.

If you choose to appeal, please complete an appeal form. You must send an appeal request form *within 30 days* of receiving this letter saying you want someone else to review your screening results. A friend, relative or other person can send the appeal form for you. Appeal Request Forms are available on the Internet at http://www.dmas.virginia.gov/#/appealsresources, or by calling (804) 371-8488. You may also contact the local department of social services.

If you are not able to obtain the appeal form, you may write a letter to request an appeal. Please include your name, date of birth, social security number, case number, the agency that conducted the LTSS screening, and the date of the LTSS screening. Please send a copy of this letter with the appeal request to the:

Appeals Division
Department of Medical Assistance Services
600 E. Broad Street
Richmond, Virginia 23219
Appeal requests may also be faxed to:
(804) 452.5454

It has been our pleasure to work with you. If you have any questions, feel free to call us at **[Insert phone number here]**.

Sincerely,

(Name/Title of a Screening Team Member)
Medicaid LTSS Screening Team
(Name of Agency or Hospital)

C: